Health Information Technology Standards Committee
Final
Summary of the April 20, 2011, Meeting

KEY TOPICS

1. Call to Order

Judy Sparrow, Office of the National Coordinator (ONC), welcomed participants to the 24th meeting of the Health Information Technology Standards Committee (HITSC). She reminded participants that this was a Federal Advisory Committee meeting, with an opportunity for the public to make comments, and that a transcript of the meeting would be available online. She conducted roll call, and turned the meeting over to Acting National Coordinator for Health Information Technology Farzad Mostashari.

2. Opening Remarks

Mostashari began by discussing the upcoming summer deliverables. He explained that Doug Fridsma will be discussing the process and timelines for taking the recommendations from the HIT Policy Committee (HITPC) and transforming those into deliverables for which the HITSC is responsible. Deliverables include proposed certification criteria proposed as well as standards. Mostashari commented about the balance between the two Committees and the important roles they play, including those of serving as the connection points to the outside community.

3. Review of the Agenda

HITSC Chair Jonathan Perlin acknowledged the accomplishments as of this 24th HITSC meeting, noting that the group has moved from developing a conceptual framework to a process that represents the legacy of those early activities. He reiterated the goal remains the higher value, more effective, safer, more efficient health care to which all aspire. In reviewing the meeting's agenda, he explained that this meeting would bring the numerous efforts that intersect from past activities and provide clarity for the next sequence of activities for meaningful use Stage 2 and 3. Perlin commended John Halamka for holding the Committee to its tasks.

- **Action Item #1:** The minutes of the last HITSC meeting, held on March 29, 2011, were approved by consensus.

Halamka explained that *ad hoc* "power teams" will be created to help move the Committee and the process through all of the different tasks. These power teams will assist and supplement existing HITSC workgroups.

4. Meaningful Use Stage 2 Update and Discussion

Paul Tang reminded the group that over the past several months a number of hearings have been convened to help fill the knowledge base and obtain feedback on a number of topics related to specialists, hospitals, state issues, Medicaid, and general ways that meaningful use can be applied to health measures and utilized to reduce health care disparities.

In December, the initial Stage 2 draft criteria concept was presented to both the HITSC and the HIT Policy Committee (HITPC). ONC staff summarized those comments and the Meaningful Use Workgroup is reconciling the input received as well as the input from other workgroups, both within the HITSC and HITPC, to finalize the initial draft recommendations that will be presented to the HITPC on May 11. The goal is to have final Stage 2 recommendations from the HITPC for approval at its June 8 meeting. Tang summarized the comments received as follows:

- An endorsement for the meaningful use program in the sense of how it was structured and the kinds of categories that support better health.

- General support for the existing objectives. There was strong support for a number of new objectives introduced as part of initial Stage 2 concepts, such as adding e-prescribing for outpatient medications.

- There was some mixed support for some other new objectives, such as advanced directives for eligible providers.

- The biggest concerns related to whether industry can move this fast and that the objectives are developed and disseminated in such a way that does not cause inadvertent side effects or harm.

The meaningful use timelines are based on the goal of having all American's health care history in electronic health records (EHRs) by 2014. To address some of the timing concerns (e.g., those related to EHR vendor development time, provider implementation and training time, health information exchange [HIE] governance time, etc.), the Workgroup developed a series of options for consideration. One option keeps the same timeline and the same 1-year reporting period, with a mix of new functionality and existing functionality with potentially different thresholds. A second option is to reduce the 1-year reporting period to, for example, a 90-day reporting period as exists for Stage 1. A third option is to delay the start of Stage two by some set period of time (e.g., 1 year, 6 months, etc.). Some new requirements need further clarification and attention, and there is significant concern about time required for development and implementation of new functionality. HITPC workgroups also are engaged in developing related recommendations. For example, the HITPC Quality Measures Workgroup is discussing the potential incorporation of patient reported measures.

Discussion

- Jonathan Perlin commented that the focus needs to be on standards development—given what is understood about the proposed Stage 2 criteria, what can be offered back in terms of

parsing that level of availability of standards as the HITPC and ONC contemplate different permutations of timing?

- Farzad Mostashari commented that during the last round, the HITSC should have considered the certification criteria as well as the standards. What are the objective tests that could be implemented?

- John Halamka expressed supporting the idea of having the Committee participate in the development of certification criteria. The Implementation Workgroup has already been asked to be engaged. Working to ensure that those criteria are reasonable is important.

- Paul Tang discussed structured lab results as a menu option for Stage 1; the intent is to move this into core. Tang also noted that with regard to the President's Council of Advisors on Science and Technology (PCAST), there was a recommendation for Stage 2 to apply some of the PCAST Report's concepts—for example, the metadata tagging, to the downloadable record that a patient can request out of an EHR.

- Doug Fridsma commented on performance testing and emphasized the tremendous amount of value associated with ensuring that there is tight coupling between police and technology early in the process, before recommendations are finalized.

- Wes Rishel noted the importance of keeping in mind the limits of certification. There is a great deal of quality data for Stage 1 being captured after discharge. Changing the threshold for moving something from a menu to required can imply a functionality change for the vendor. Obtaining feedback from Stage 1 on what is being attested to would be helpful.

- Stan Huff offered his opinion that criteria should be more for interoperability and creating the sharing of information and less about particular functions or about informing consumers.

- Carol Diamond reminded the group that the objective of meaningful use is to actually improve quality. She specifically discussed the new requirements in meaningful use, noting that that there are some elements in the new requirements that have had mixed input. It would be helpful if the Committee could provide technical recommendations on how these might be implemented to address some of those concerns. Josh Seidman responded by noting that at last week's HITPC meeting, the National Quality Strategy was presented. This lead to HITPC discussion about Stage 2 and future stage meaningful use criteria and objectives in this context.

- Janet Corrigan pointed to patient-reported outcome measures as representing a transformative shift in the kinds of measures that are being used. These would begin to capture health functioning, health risk appraisal, and health behavior information.

- Perlin summarized the discussions to this point by explaining that the comments included an emphasis on interoperability and the need to consider functional outcomes. He reminded the group that currently, physician offices, hospitals, long-term care facilities, and patients

themselves generally have not completed acquiring the technologies necessary for these next steps.

- David McCallie asked about cross-provider interoperability. Tang commented that the high-level comments in his presentation were not comprehensive, and that there will be an emphasis on HIE.

- Walter Suarez, questioned timing and the synchronization of all of the different steps and the engagement that will have to occur before a final rule is issued. His main concerns related to the compressed time between the moment when the final regulation on certification standards is issued and when the implementation will have to take place.

- Kevin Hutchinson discussed e-prescribing for discharge medications and the associated challenges. In terms of workflow, it is critical that a prescription from a discharge medication is identified as a discharge medication, and that the follow up physician is also identified in that order so that the pharmacist can make sure that the follow up physician is in agreement with the medication order.

- Paul Tang responded to some of the questions and concerns raised during discussion. With regard to a commented about the National Quality Strategy, the intent is to reconcile the approaches—even those of Stage 1—with the National Quality Strategy. Tang also clarified that there is a separate workgroup addressing clinical quality measures. Much of this group's work will address Stage 3, given the nature of these efforts and the need for development lead time.

- Perlin summarized discussion by stating the need to ensure the group's vision is calibrated to the state of the ecosystem.

5. Process for Deliverables Between HIT Policy Committee, HIT Standards Committee, ONC/S&I Framework

Steve Posnack of ONC presented a slide showing Sections 3001, 3002, 3003, and 3004 of the Health Information Technology for Economic and Clinical Health Act (HITECH) to illustrate the relationships between the advisory committees, the National Coordinator, and the Secretary of the Department of Health and Human Services as well as the process through which recommendations from the HITPC are submitted to ONC. He explained that ONC distills and re-packages the recommendations, comes back to the HITSC and presents the priorities heard from the HITPC, and then the HITSC makes recommendations. One of the responsibilities of the Standards Committee is to make recommendations about standards implementation specifications and certification criteria. Posnack mentioned that previously, the Standards Committee did not have ample time and opportunity to recommend certification criteria. This is an area in which the Committee's input could be very valuable.

Doug Fridsma, ONC, then emphasized the important role played by the HITSC in analyzing the standards implementation of the HITPC recommendations. This will be especially useful in preparing for Stage 2; it is hoped that the HITSC will identify gaps in the standards that are there

as well as triage some of the standards work. Fridsma stated the importance of recognizing and utilizing the tools at the Committee's disposal for obtaining the input needed to be able to make appropriate recommendations, such as the opportunity to hold hearings, the ability to use the Federal Register, Wikis, working groups, and the S&I framework.

Fridsma then presented some of the HITSC action items for meaningful use Stage 2. The first action item he discussed was the "refresh/reload," within which the Committee has to recommend revisions to adopted certification criteria, and recommend new and updated standards and implementation specifications to associate with adopted certification criteria. He pointed out that there are some policy recommendations that are functional and indicate that the Committee wants to have some function available, and some that are interoperable that indicate that the Committee not only wants to enable some function, but wants to do it in a way that allows the exchange of information based on standards. He asserted that the HITSC has to be clear about those distinctions. The second action item he discussed was analyzing Meaningful Use Workgroup draft recommendations, identifying and drafting any new certification criteria, and beginning to look at the standards and implementation specifications where available.

Next, Fridsma discussed using four buckets to complete some fairly rapid triage to the available tools in order to apply them appropriately to the tasks at hand. The buckets he discussed were:

- Bucket A: Performance measures only, in which there are no standards that are needed, but the Committee needs to be able to identify within an EHR some function that it wants to support.

- Bucket B: The Committee believes that there are sufficient standard and implementation guides that have been identified and would support policy objectives.

- Bucket C: There may be existing standards, but there might not be an implementation guide that is identified, or the implementation guide may not be specific enough to be able to create the criteria that the Committee would like to achieve policy objectives, or existing standards or implementation guides are available, but additional public input is needed.

- Bucket D: There are no standards or implementation guides that have been identified, or the existing ones require substantial input.

Fridsma then discussed several other activities, such as transport mechanisms for labs and transitions of care, the Direct Project, certificate work on the X.509 standard and other work within the S&I framework, sending patient reminders, Web portal and timely access, online secure messaging, test of health information exchange, and lightweight directory access protocol (LDAP). Fridsma concluded his presentation by reviewing the details of the HITSC summer work plan, month by month.

Discussion

- Christopher Chute stated that philosophically, one major question for the Committee is when the vocabulary question should be tackled, because he personally believes that

interoperability absent semantic specification is not that useful and this question will have an impact on timing, evaluation, and some bucket assignments.

- In response to a question, Fridsma explained that in meaningful use Stage 1, CCD and CCR were adopted as standards, with C32 as the implementation guide for the CCD. Transitions of care is an initiative that is intended to have participants from the CCR and the CCD community come together and agree on what a transitions of care document should look like.

- Carol Diamond asked how the National Strategy for Trusted Identities in Cyberspace (NSTIC) will or should factor in to the work. Fridsma responded that privacy and security identity management is a critical piece that will need to be considered moving forward, but does not know where it would fit in the bucketing process.

- It was noted that the HITSC should ensure that it is working on things that are actually going to be included in the HITPC's recommendations, and not on things that are in a more expanded list which through the comment process and prioritization may potentially drop out of Stage two. It was also noted that discharge prescriptions was on the Policy Committee highly supported list, but was not included in the list presented by Fridsma.

- With regard to LDAP, John Halamka asked Fridsma whether the Standards Committee could develop one canonical recommendation for provider directory query because there does not appear to be any standards that meet all the criteria the Committee believes it should have. Fridsma explained that if there is an existing standard that is thought to serve their purposes, like LDAP, one can say that they think this is the right approach or the right standard that should be used for directories, but there is not an implementation guide available quite yet. He asked Committee members to consider how to get as much of the work done over the summer and to focus the energies within the S&I Framework on those things that fall into Bucket C.

- Dixie Baker commented on Bucket C, noting that there will be instances in which what the Policy Committee gives the Standards Committee does not fit ideally or precisely within a standard (i.e., a case in which there is an existing standard but it is not consistent with the policy prescribed by the Policy Committee). Fridsma agreed and asserted that such a case is why it is so important for the standards community and the policy community to have a dialogue about the necessary supporting technology and standards, and for how the standards community will work with the policy community to make sure that they are aligned well.

- Halamka explained that the HITSC will do its best to identify the canonical standards that will work, but if it cannot then it will do its best to pick as many of the standards it thinks will work, and specify characteristics of what additional needs there are.

- David McCallie asked about oversight for these tasks. Fridsma indicated that this work will require a concerted effort across working groups, leveraging the activities within the S&I Framework, holding hearings, etc. Fridsma also mentioned the possibility of having HITSC members participate in weekly or biweekly meetings in ONC to help to triage and then

communicate with the overall Committee and with the working groups to make sure that everyone is on track with what needs to be accomplished.

- Halamka explained that deliberations begin on specific work assignments and input is provided to the S&I Framework where necessary. The S&I Framework then feeds back the results for the Committee's comment. Then, ultimately the regulation comes out based on whatever final recommendations are made. All input from all sources is taken and put it into meaningful and thoughtful regulation.

- Walter Suarez asked for clarity about the expectations from the summer work plan, and at what point after the summer the HITSC will issue recommendations on all the standards for all of the different items. Fridsma explained that he would like to receive the recommendations on an incremental basis, possibly every month until the end of August. Suarez followed up by asking if the expectation would be that the end of August would be the last time recommendations could be made, given that some of these activities could take until November or December.

- Wes Rishel suggested that in the interest of priority setting, it be assumed that anything that is produced through a standards development organization-like consensus process will have ambiguities and be fitted to a broader community than what can be used as a testing basis for certification. Unless it is proven otherwise, there is a need for an ancillary specification. He also discussed the important need to recognize that vocabularies are not a plug-in, and that that is often a type of addition that is applied to a standard after the fact, rather than as part of the standards process.

6. PCAST Report Workgroup – Results of Analysis

Paul Egerman presented a brief summary of the PCAST Report Workgroup. The Workgroup has been charged to:

- Assist ONC in synthesizing and analyzing the public comments and input received on the PCAST Report.

- Discuss the implications of the report and its specific recommendations to ONC on current ONC strategies.

- Assess the feasibility and impact of the PCAST Report on ONC programs.

- Elaborate on how these recommendations could be integrated into the ONC Strategic Framework.

The PCAST Report has three major directions. The first is to accelerate progress. The second involves new exchange architecture. The third major direction relates to an evolutionary transition. In describing these three major directions, Egerman emphasized that the PCAST Report and this new exchange architecture is not intended to be a complete description for everything that happens related to information exchange.

The PCAST Report Workgroup was divided into two taskforces. One taskforce dealt with policy issues, and the other taskforce dealt with implementation and technology issues. The taskforce on policy issues identified a number of policy-related areas for future work. These include privacy and security and multi-patient, multi-entity analysis.

The implementation taskforce, influenced by some of these policy issues, looked at four use cases for the system: (1) push by patient between two points, (2) simple search, (3) complex search, and (4) de-identified aggregate data search and retrieval. Specific recommendations were not made but a few alternatives were described that ONC might consider for Stage two of meaningful use. The first alternative involves a patient portal so that patients could have access to their EHR data. This alternative does not require tagging each individual data element, although they are already tagged within the CCD and the CCR. The second alternative involves providing certification criteria for other exchange transactions.

Egerman summarized that the PCAST Report describes a national use of advanced technology. It provides a compelling vision for how that technology could be beneficially used as an important aspect of the learning health system. There are major policy and operational feasibility concerns with the proposed technology, and aggressive and rapid progress is possible only with an incremental test-bed approach. Large operational tests are needed that resolve the policy and feasibility concerns.

7. Mitre Analysis of Existing Metadata Standards

Doug Fridsma began by thanking Paul Egerman for all of his work, time and leadership. Fridsma explained that over the 2 weeks prior to this meeting the group reached out to the team from MITRE that has been working on some of the quality measure analysis and asked them to help accelerate the progress towards getting some standards or identification of the components that might be needed to implement the PCAST vision.

One of the items that came out of this report is that there are a few of metadata element categories that were going to be fundamental. Potential metadata elements are provided for the following categories: patient matching, provenance, and consent. For each element, standards that reference similar metadata have also been identified.

With regard to patient matching, the goal is to find all of a patient's tagged data elements in multiple data element access services (DEASs). The challenges include bias towards false negatives, privacy versus accuracy, differences in name structure between cultures, time sensitivity of name and address, and social security number (which is a good identifier, but poses too many issues to be fully used).

With provenance, the goal is to determine the "who, what, when, where, why and how" of tagged data elements (TDEs). The challenges are tagged data element versus content provenance, many Health IT standards have pieces of provenance information, but they do not capture the complete picture, and "full" provenance for TDEs is unlikely to be populated and expensive to maintain. It should start with shallow provenance and increase over time. It is encouraging to know that there are provenance standards out there that incorporate many of these elements.

Consent adds additional challenges. The goal is to express what TDEs can be shared with a party in a situation. The challenges are conceptual vs. concrete policy, choosing correct granularity, and inadvertent disclosure of sensitive information (e.g., disclosing the existence of an HIV test even if the result is not disclosed).

Fridsma summarized that these issues are just a few of the ones related to these particular data elements that look at granular consent, patient matching, and the provenance or the context from which that information was obtained. Fridsma emphasized this is not the end of the analysis, just the beginning.

Discussion

- Walter Suarez commented on the challenge of the UEL version 0 and incorporating that into meaningful use Stage 2. Who is really the entity that defines that standard that then can be named and adopted and incorporated into meaningful use and then incorporated into the certification process? Suarez also commented on the metadata component, stating that the biggest concern and challenge relates to the DEAS infrastructure and the entities that would become those DEAS service agencies.

- Fridsma explained that in the initial analysis, the goal has been trying to figure out what the it would look like if a UEL was established and what that metadata might look like. These have to fit into a policy scheme that is able to disambiguate the request and the data.

- Suarez noted the need for demonstrations and testing.

- Fridsma emphasized that the goal is to take an incremental approach and to try to accelerate the ability to exchange information.

- David McCallie noted that the description of provenance did not include the notion of a digital signature to keep the document tamper-free. Egerman explained that in the PCAST Report, there was a great deal of emphasis on patient engagement and discussion about the personal health record (PHR).

- Dixie Baker suggested revising some of the privacy and consent issues. As one of the PCAST members often pointed out, privacy does not equal consent; they are not synonymous. The three elements of metadata that we identified as essential were the identity element, the provenance element, and the privacy and security, not consent. Paul Egerman explained that the PCAST Report does describe usage of this entire system for deidentified data which in this case the attributes presumably would have the patient identification material removed but might still have other information in it that might help in terms of context.

- Carol Diamond commented that in many of the recommendations there is language indicating the need to create policies. She pointed to the need to have these policy-related conversations occurring along with standards discussions and selection about the attributes of the metadata, because metadata can be disclosing. She also noted that it is important for some of the meaningful use requirements and the general consumer access requirements that

the capability to download a patient's information comes unfettered from requirements for using a service or an application in order to read it.

- Wes Rishel commented that the most important impact of the PCAST Report has been to create the opportunity for ONC to enhance its focus on meaningful use. Many of the individual features or ideas in the PCAST Report are applicable in constrained environments even while policy issues are being addressed and resolved.

8. Clinical Quality Workgroup Update

Jim Walker stated that the Clinical Quality Workgroup believes that its first order of business is to review the National Quality Forum's (NQF) Quality Data Model (QDM), with an eye to its utility and extensibility across the range of quality measures that they will need to be implementing over the next several years. Particular attention will be given to care coordination, capture of data from multiple sites, patient-entered data, and the other new imperatives for meaningful use Stages 2 and 3.

Walker continued by mentioning several scoping considerations. The consensus of the Workgroup was that for population management, the QDM could be responsible for capture of person-level data, which would then be aggregated in other settings. With patient safety data, the QDM needs to be capable of capturing that person-level data to be fed forward to things like the HRQ common format. In terms of documentation of evidence quality and documentation of population size required for measure application, Walker said that the Clinical Quality Workgroup thought those were both two critically important issues to be clear about as the measures are created, but that it was the consensus that both of those issues are logically prior to implementation of quality measures in the QDM. They would be things that guideline developers and others would be responsible for characterizing prior to the QDM, and would not need to be part of the QDM's model. Next, Walker stated that the Workgroup thought it would be useful to be clear about the target audiences for the QDM, and listed guideline developers, quality measure developers, HIT manufacturers and provider-organization measure developers as the target audiences.

The Clinical Quality Workgroup believes the next important activity is to understand clearly what it was about meaningful use Stage 1 measures that made them useful and usable, and what was it about them that could be improved so that they either are better at getting at what they are intended to get at in terms of quality, or that they are easier to implement and make effective use of. He mentioned a planned panel with the Meaningful Use Workgroup of the HITPC during which they want to hear from a large representative of stakeholders, and asked HITSC members for suggestions about additional stakeholders and panelists who are knowledgeable, and who can help determine how to move forward effectively.

Walker stated that the Workgroup is going to receive help at its next meeting in looking at the QDM as it would support use cases around population management. The Workgroup also will be looking at Stage 2 measures, first to determine what measures could be ready given the very tight timeline for Stage 2, and further to consider the more substantial, fundamental enhancements that will take a little more time, and be appropriate for Stage 3.

Discussion

- Judy Murphy asked whether as part of the Clinical Working Group activity, there was a plan to get comments back to NQF, and if there was a formal activity to do so. Walker indicated the Floyd Eisenberg has been present all of the Workgroup meetings, and that feedback is being provided through him. Eisenberg indicated that the new version of the QDM had just been posted as two documents, one a general overview and the other a technical specification that is open to comment from the public, members of the Committee, and others. He indicated that the comments would be incorporated and the provided back to the Clinical Quality Workgroup.

- Judy Murphy asked whether the Clinical Quality Workgroup would be documenting what made the quality measures helpful or useful, to which Walker answered that they would.

9. Privacy and Security Standards Workgroup Update

Dixie Baker began by reminding the Committee that at the last meeting, they had approved all three of the Privacy and Security Standards Workgroup's recommendations. She presented a copy of the transmittal letter that was sent from the Committee to ONC with those three recommendations. Baker reminded the group that the first recommendation was for specific requirements and evaluation criteria for standards for digital certificates. The second recommendation was that ONC investigate the benefits and alternatives of cross-certifying direct certificate authorities, that is certificate authorities that issue digital certificates for direct exchanges with the federal bridge, and stated that the explicit calling for the examination of the potential benefits of cross-certifying the federal bridge CA was added. The third recommendation was that the HITPC recommend policy and governance to establish a minimum level of trustworthiness of certificate authorities that issue certificates for use in direct exchanges.

Baker continued by providing outcomes from the March HITSC meeting, which included addressing both entity-level and individual-level provider directory standards at the same time. She mentioned that the Workgroup had run into a complication due to the fact that it was anticipated that the individual-level provider directory policy recommendation would be approved by the HITPC on April 13, but it has been postponed to the May 11 meeting. However, they are working on the same schedule, and will be prepared to make adjustments after the May 11 meeting if need be.

Next, Baker noted that the Workgroup had heard testimony in the last month from the Social Security Administration and the X12 community. Later this month, the Workgroup will hear testimony from HL-7 on their efforts in provider directories, and from a speaker who has been working with the Massachusetts Health Information Exchange who will talk about their experiences. Although the HITPC has separately addressed enterprise-level and individual-level provider directories, the IHE profile addresses and accommodates both. One can use the same profile to implement both individual-level or entity-level provider directories. She classified these existing standards under Bucket C because the Workgroup thinks this set of standards may

need to be tweaked, but also thinks it provides a good input in the whole standards that the Workgroup will be recommending.

The discussions with the X12 community emphasized the importance that a provider directory include not only information of use for clinical exchanges, but also the importance of provider directory for administrative transactions as well. The X12 community has developed two implementation specifications, one for the provider directory and one for the provider inquiry of that directory. She pointed out that the X12 is a transaction standard, and so it does not define a structure for a provider directory, and neither does the IHE profile, but that both of them allow for both a centralized directory as well as for federated directory query. Baker emphasized that the provider directory does need to maintain information regarding a provider's membership in health plans and health plans' provider networks such as the provider specialty, whether that provider is taking patients at a particular point in time, and providers' characteristics that may be useful for both consumer queries of the directory, as well as for providers' queries of the directory. All of these are included in the X12 provider directory.

Baker then presented the data elements that are included in the X12 provider directory transaction standards. She noted that all of the approaches that have been presented to the Workgroup so far have looked at provider directories as a single integrated structure that contains both enterprise and individual directory information rather than a separate directory system, while the X12 directory accommodates both queries for an enterprise as well as queries for an individual. The Workgroup concluded that the standard that they recommend needs to be implementable at both the individual and enterprise levels, as well as in a centralized or federated implementation. Baker also stated that the provider directory standard needs to accommodate the needs of not only providers, but of payers and of consumers as well. Finally, she cautioned the Committee that the IHE healthcare provider directory profile has been demonstrated twice through two use cases at the interoperability showcase, but it has never been fully implemented in a production environment. Baker concluded by presenting the Workgroup's schedule moving forward.

Discussion

- Jonathan Perlin emphasized that as the Workgroup recommends standards, now having buckets, that they try to think about the "little guy" and if there are standards that have never actually been implemented in the field which might not be appropriate for the "little guy" as the field moves toward rapid implementation in Stage 2 timeframes.

- David McCallie asked about the core requirement around the ability to federate independent directories, and whether the assumption is that the model will be a federated model of some kind, and whether that debate is still open. Walter Suarez noted that the HITPC recommendations separated from a policy perspective the entity level from the individual level. He stated that on the entity level conceptually, the policy recommendations were that it will work very well if it was more of a combination of centralized with federated, meaning there will be multiple entity level provider directories, but some sort of a national directory system. He indicated that it likely is not the responsibility of the Standards Committee to define the infrastructure aspects of it, and that it is more the Committee's responsibility to

ensure that the standards work in whatever mechanism, whether it is more centralized, more federated, or a combination of the two.

10. Public Comment

Robin Raiford, Allscripts, commented on the issue of patients who have two EHRs, one in the emergency department and one in the hospital. These EHRs are separate and both have two sets of data. Both EHRs have their certified data to present for quality measures. CMS wants a single file per CCN, and currently the NIST criteria do not have such a thing as certified for aggregating data. Raiford asked if there was a way to have aggregation on the CMS end so that the entire nation is not doing self-certification to blend these two files together. This is a challenge facing organizations with two EHRs as well as eligible professionals who practice in more than one location with different EHRs.

Prior to adjourning the meeting, there was a discussion of the next steps going forward. John Halamka mentioned the need for a detailed work plan for the summer months. He also mentioned looking at that work plan in the context of what are the things that, if not done, will derail all of the work on meaningful use Stage 2 and the certification rule. He also pointed to the need to assemble a group to examine PCAST issues and offer recommendations to Doug Fridsma. Fridsma added that it may be useful to establish some ad hoc working groups to support these efforts.

SUMMARY OF ACTION ITEMS:

Action Item #1: The minutes of the last HITSC meeting held on March 29, 2011, were approved by consensus.